LINDA M. LAWRENCE, M.D.
— Ophthalmology —
Surgery and Diseases of the Eye
1410 E. Iron, Suite 6 · Salina, Kansas 67401
Phone: (785) 823-1600 · Fax: (785) 823-8953

AUTHORIZATION FOR THE RELEASE AND/OR DISCUSSION OF PROTECTED HEALTH INFORMATION

Patient Name_____________________________________ Birth Date______________

I, _________________________________ hereby authorize
(Patient or legal representative)

____
Name of person, organization or physician

_____To release my complete health record(including records relating to mental healthcare, communicable diseases HIV/AIDS, and treatment of alcohol or drug abuse).

_____With the exception of:
___ Mental Health Records
___ Communicable Diseases(including HIV/AIDS)
___ Alcohol/drug abuse treatment
____Other(specify)__________________________

To: Linda Lawrence, M.D., 1410 E Iron, Ste 6, Salina, Ks 67401

This information may be used for medical treatment, consultation, or other purposes as I may direct.

I have carefully read and understand the above information, and do herein consent to its disclosure. I am aware that information regarding my medical condition will be released to those persons or agencies named above. I understand that this consent is subject to revocation, in writing, at any time, unless action based on it has already begun. This authorization expires one year from today's date.

Signature____ Date______________

Relationship to patient____________________________

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